Tension-type headache

Tension-type headache

Latest update: 2010. **Next update**: Within 5 years. **Patient group**: Adults with a tension-type headache as defined by the International Headache Society. **Intended audience**: Clinicians managing patients with tension-type headaches. **Additional versions**: Nil. **Expert working group**: A task force of 6 representatives from the European Federation of Neurological Societies (EFNS), associated with Neurology Departments in Denmark, Germany, Sweden, Norway, Greece, Italy and Belgium.**Funded by**: European Federation of Neurological Societies. **Consultation with**: Representatives of over 20 British and American medical societies, including the APTA and the Chartered Society of Physiotherapists. **Approved by**: EFNS. **Location**: The guidelines were published as: Bendtsen L et al (2010) EFNS guideline on the treatment of tension-type headache – report of an EFNS task force. *European Journal of Neurology* 17: 1318–1325. They are also available at: http://www.efns.org/fileadmin/user_upload/guidline_papers/EFNS_guideline_2010_treatment_of_tension-type_headache.pdf

Description: These guidelines present evidence for the acute and prophylactic treatment of tension-type headache using drug and non-drug interventions. It begins by outlining the known epidemiology of tension-type headache, common clinical characteristics, and diagnostic criteria. Evidence for drug treatment of acute tension-type headache is then presented, covering simple analgesics, non-steroidal anti-inflammatory drugs, combination analgesics, triptans, muscle relaxants and opioids. Next, evidence for prophylactic pharmacotherapy is presented, discussing interventions including amitriptyline, other antidepressants and other agents such as muscle relaxants or botulinum toxin. The final section details evidence for non-pharmacological interventions including EMG biofeedback, cognitive-behavioural therapy, relaxation training, physical therapy, acupuncture, and nerve blocks. Physical therapy in this guideline encompassed a variety of treatment options, such as exercise, manipulation, massage, and electrotherapy and was investigated in 13 articles. Overall, the guidelines are supported by 129 references.

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Arthroscopic shoulder surgery

Arthroscopic Anterior Capsulolabral Repair of the Shoulder

Latest update: 2010. **Next update**: Not indicated. **Patient group**: Adults who have undergone an arthroscopic anterior capsulolabral repair of the shoulder to restore stability. **Intended audience**: Therapists involved with the rehabilitation of patients who have undergone this surgical procedure. **Additional versions**: Nil. **Expert working group**: Six representatives from the American Society of Shoulder and Elbow Therapists (ASSET) including physical therapists, an orthopaedic surgeon, and an athletic trainer. **Funded by**: Not indicated. **Consultation with**: Guidelines were sent to all members of ASSET for comment. This included American and international physical therapists, athletic trainers, and occupational therapists, in addition to orthopaedic surgeons. **Approved by**: ASSET and the American Shoulder and Elbow Surgeons Society. **Location**: The guidelines were published as: Gaunt BW et al (2010) The American Society of Shoulder and Elbow Therapists' consensus rehabilitation guideline for arthroscopic anterior capsulolabral repair of the shoulder. *Journal of Orthopaedic and Sports Physical Therapy* 40: 155–168 and are available at: http://www.asset-usa.org/Rehab_Guidelines.html

Description: These guidelines relate specifically to patients who have undergone arthroscopic anterior capsulolabral repair in which the detached labrum has been anchored back to the glenoid rim and/or capsular tension has been restored through suture tightening of the plicated capsule. They are based on the best available evidence, along with ASSET member expertise and clinical opinion. The article begins by providing detailed information about this surgical procedure, the likely anatomical structures affected, tissue healing, and factors including mechanical stress that could influence the progression of healing such as exercise and immobilisation. The second half of the document outlines rehabilitation guidelines across three phases: weeks 0 to 6, 6 to 12, and 12 to 24. The guidelines are presented in detail at the end of the document and include goals, interventions to avoid, specific interventions such as techniques to gain range, neuromuscular re-education, strength, endurance, and pain management.

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